

1
FOR STATE
HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **00729**

745

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond (rural) c. LENGTH OF STAY IN 1b Baltimore 4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1201 Purdy Court			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 4 d. STREET ADDRESS 1201 Purdy Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First KARL Middle ARON Last ARON			4. DATE OF DEATH Month January Day 14 Year 1959		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH June 20, 1925		9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months 33 Days 0	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Albert William Aron	
14. MOTHER'S MAIDEN NAME MARGARET SCHENK		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 353 18 6122	
17. INFORMANT Thomas A. Brant		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries 863x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 863x DUE TO (c) 863x		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Airplane crash			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Airplane crash		20c. TIME OF INJURY Month, Day, Year 11:55 a.m. 1/14 1959			
20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm			
20f. (City or town) Nr. Still Pond		20g. (County) Kent		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/15/59	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Jan. 17, 1959		22c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory	
22d. LOCATION (City, town, or county) Baltimore, Maryland		22e. (State) Md.		22f. (City, town, or county) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR Jan 19 59		24b. REGISTRAR'S SIGNATURE Arthur L. Fisher	

OFFICE OF THE MEDICAL EXAMINER
STATE OF NEW YORK

REMOVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

746

CERTIFICATE OF DEATH

00730

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown RFD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown RFD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home Broad Neck				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Emily Berry				4. DATE OF DEATH Jan. 9, 1959 Month Day Year			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1887	
9. AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York State	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME unknown Moger				14. MOTHER'S MAIDEN NAME unknown Moger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 214-03-9638		17. INFORMANT Sons Raymond and Berry John	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arterio Sclerosis - secondary (b) Arterio Sclerosis - secondary (c) Arterio Sclerosis - secondary				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 15, 1956 to Jan 9, 1959 that I last saw the deceased alive on Jan 9, 1959 and that death occurred at 8:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert C. Nitsch				ADDRESS (Street, city or town, state) Rock Hall, Maryland			
PHYSICIAN'S NAME (Type) Robert C. Nitsch				DATE SIGNED 1/10/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/59		22c. NAME OF CEMETERY OR CREMATORY Chestertown Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JAN 13 1959	
				24b. REGISTRAR'S SIGNATURE Arthur L. Howell			

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chestertown (RFD Georgetown)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home RFD				d. STREET ADDRESS RFD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Grace		First Grace		Middle Briscoe	
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Mar. 1, 1888		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent CO. Md.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Russell		14. MOTHER'S MAIDEN NAME Anna Washington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease (to my knowledge) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour 41 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of left breast with metastases		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-8 , 1958 , to Jan. 18 , 1959 , that I last saw the deceased alive on 1-12 , 1959 , and that death occurred at 6:30p. M., from the causes and on the date stated above ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED Jan. 19, 1959					
ACTUAL SIGNATURE A.C. Dick M.D.		22. NAME OF CEMETERY OR CREMATORY Georgetown Cem.			
PHYSICIAN'S NAME (Type) A.C. Dick		22d. LOCATION (City, town, or county) (State) RFD Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/59			
23. FUNERAL DIRECTOR'S SIGNATURE Samuel W. Waller		23a. ADDRESS Chestertown, Md.			
24a. REC'D BY REGISTRAR JAN 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00732

737 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown RFD		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Anne's Hospital		e. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Cynthia First Brown Middle Brown Last		4. DATE OF DEATH Jan. 30 Day 30 Year 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1958
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR 7 Months	11. IF UNDER 24 HRS. 7 Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George H. Brown	
14. MOTHER'S MAIDEN NAME Mildred Scott		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) n	
16. SOCIAL SECURITY NO. no		17. INFORMANT Mildred Brown Address Georgetown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition and severe dehydration 493X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Vomiting & Diarrhea DUE TO (c) Pneumonia			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. IV	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-25-59 , 19 59 , to 1-30-59 , 19 59 , that I last saw the deceased alive on 1-30-59 , 19 59 , and that death occurred at 12:35 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1-31-59 DATE SIGNED			
ACTUAL SIGNATURE Harry Paul Ross M.D.		PHYSICIAN'S NAME (Type) 203 N. Queen Street, Chestertown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/1/59	22c. NAME OF CEMETERY OR CREMATORY Georgetown, xx. Cem.	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Georgetown ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR FEB 2 '59	24b. REGISTRAR'S SIGNATURE Arthur S. House

2072235XV6

1918

STATE DEPARTMENT OF HEALTH - CHICAGO, ILL.

CERTIFICATE OF DEATH



Form with multiple horizontal lines for text entry, organized into sections. The text is mostly illegible due to fading and bleed-through from the reverse side of the page.

738
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 400 Calvert St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harriett Middle M. Last Brown				4. DATE OF DEATH Month Jan. Day 22 Year 1959			
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. T. Murray				14. MOTHER'S MAIDEN NAME Henrietta Graves			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Elizabeth Black Address 400 Calvert St. Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 334X DUE TO Cerebral Arterio-Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitis						INTERVAL BETWEEN ONSET AND DEATH one month many years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 58 , to Jan. 22 , 19 59 , that I last saw the deceased alive on Jan. 22 , 19 59 , and that death occurred at 5 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 1/23/59 ACTUAL SIGNATURE Robert W. Farr M.D. PHYSICIAN'S NAME (Type) Robert W. Farr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1959		22c. NAME OF CEMETERY OR CREMATORY James Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JAN 27 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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739

CERTIFICATE OF DEATH

00734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>QUEEN ANNE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUDLERSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT & Q.A. HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM C CAREY</u>		4. DATE OF DEATH Month Day Year <u>JAN 7 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 21-1879</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>GREYSBORO AID</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Carey</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET PINDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>HOSPITAL CHAIR</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF PROSTATE</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-7</u> , 19 <u>58</u> , to <u>1-9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-8</u> , 19 <u>59</u> , and that death occurred at <u>8</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>CHESTERTOWN 1-9-59</u> PHYSICIAN'S NAME (Type) <u>A. T. KEEFE, JR. MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>JAN 12-59</u>	<u>Greenwood</u>	<u>Greenwood Cemetery Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. [Signature]</u>		ADDRESS <u>Baltimore Md</u>	24a. REC'D BY REGISTRAR DATE <u>JAN 12 59</u>
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



740

CERTIFICATE OF DEATH

00735

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Richard Edmund Cook, Jr		4. DATE OF DEATH Month Day Year Jan 1 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 31, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Edmund Cook		14. MOTHER'S MAIDEN NAME June Bell Everett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. *****	
17. INFORMANT Mother & Hospital records, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal stalectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Prematurity (Duration of pregnancy—28-29 weeks) DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 31, 1958 , to Jan 1, 1959 , that I last saw the deceased alive on Jan 1, 1959 , and that death occurred at 11:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED Jan 1, 1959	
PHYSICIAN'S NAME (Type) Robert W. Farr, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/4/59	22c. NAME OF CEMETERY OR CREMATORY SUDLERSVILLE CEM.	22d. LOCATION (City, town, or county) (State) SUDLERSVILLE MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Sellers		24a. REC'D BY REGISTRAR DATE JAN 5 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNES' HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle EATON Last EATON		4. DATE OF DEATH Month JANUARY Day 13 Year 1959	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 27, 1868
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State of foreign country) PENN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANTHONY HEWES <i>ughes</i>		14. MOTHER'S MAIDEN NAME MARY DAVIES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition & Dehydration DUE TO Advanced Age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Age DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 12 , 19 58 , to Jan 13 , 19 59 , that I last saw the deceased alive on Jan 12 , 19 59 , and that death occurred at 11:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William M. Gatewood		ADDRESS (Street, city or town, state) Rock Hall Md DATE SIGNED 1/13/59	
PHYSICIAN'S NAME (Type) William M. Gatewood			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/16/50	22c. NAME OF CEMETERY OR CREMATORY St. Paul Cem.	22d. LOCATION (City, town or county) (State) near - Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frank's Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE 1 5 '59	24b. REGISTRAR'S SIGNATURE M. E. Sims

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00737

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Delaware	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 45 minutes	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharon Hill
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes		d. STREET ADDRESS 66 North Clifton Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) John Robert Elliott		4. DATE OF DEATH Month January Day 11 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14 1885
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY Phila Elec. Company	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John B. Elliott	
14. MOTHER'S MAIDEN NAME Adelaide Turner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 181 10 4047		17. INFORMANT Edward Elliott (son) Address 206 Cowbell Rd, Willow Grove Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO History of several attacks of acute coronary insufficiency, with pulmonary edema in past three years.			INTERVAL BETWEEN ONSET AND DEATH 90 minutes Don't know
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/11 , 19 59 , to 1/11 , 19 59 , that I last saw the deceased alive on 1/11 , 19 59 , and that death occurred at 11:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 1/11/59 SIGNATURE Robert W. Farr M.D. PHYSICIAN'S NAME (Type) Robert W. Farr			
22a. BURIAL, CREMATION, REMOVAL (Specify) 1	22b. DATE THEREOF 1/11/59	22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.	22d. LOCATION (City, town, or county) (State) Yeadon - Dela. Co. Penna
23. FUNERAL DIRECTOR'S SIGNATURE William Wells		24a. REC'D BY REGISTRAR 1-12-59	24b. REGISTRAR'S SIGNATURE Charles S. Jones



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00738

748

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gettysburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gettysburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Howard</u> Last <u>John</u>		4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>19</u> Hours <u>40</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Only Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant Trading</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Norman John</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>17-12-1224</u>	
17. INFORMANT <u>Mrs. Anne Volker</u>		Address <u>Gettysburg, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>pleural effusion + asthma</u> DUE TO (c) <u>arteriosclerosis, generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>8 years</u> <u>20 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic diarrhoea - NOT malignant</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> , 1953, to <u>Jan</u> , 1959, that I last saw the deceased alive on <u>Jan 9</u> , 1959, and that death occurred at <u>1:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Florence Gertrude Joyce</u> M.D.		ADDRESS (Street, city or town, state) <u>Worben, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Florence Gertrude Joyce</u>		DATE SIGNED <u>1/13/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/13/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>	22d. LOCATION (City, town, or county) (State) <u>Gettysburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kraw</u>	
ADDRESS <u>3011 10th St.</u>		DATE <u>JAN 13 '59</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

749

CERTIFICATE OF DEATH

Reg. Dist. No.

00739

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Chestertown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown - rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home - RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles David Lewis</u>				4. DATE OF DEATH Jan. 20, 1959			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 20, 1917</u>	9. AGE (In years last birthday) <u>42</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>various</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Martha Harger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>110</u>		17. INFORMANT <u>Admi. Miller Chestertown, Md. Sister</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4 <u>4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Jan 18</u> , 19 <u>58</u> , to <u>Jan 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 18</u> , 19 <u>59</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. D. Kester</u>		ADDRESS (Street, city or town, state) <u>Rock Hill, Md.</u>		DATE SIGNED <u>1/20/59</u>			
PHYSICIAN'S NAME (Type) <u>Eugene Kester</u>		<u>Rock Hill, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>1/22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monoma Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>near - Chestertown, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Waller</u>		ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William L. Kester</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



750
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>				c. LENGTH OF STAY IN 1b <u>15 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>none</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>			
f. STREET ADDRESS <u>Chesapeake Ave</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Jacob</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>10</u> Year <u>19 59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 26 1883</u>	
9. AGE (In years last birthday) <u>75</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Miller</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Steinkacker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>202-01-0513</u>		17. INFORMANT Address <u>Adelaide Miller Rock Hall</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cardiovascular</u> DUE TO (c) <u>Carcinoma of Bladder</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 2, 1957</u> to <u>Jan 10, 1959</u> , that I last saw the deceased alive on <u>Jan 9, 1959</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rock Hall Md</u> DATE SIGNED <u>Jan 12 1959</u>							
ACTUAL SIGNATURE <u>Herbert C. Nitch</u> M.D. <u>Rock Hall Md</u>							
PHYSICIAN'S NAME (Type) <u>HERBERT C. NITCH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JAN. 14</u>		<u>North Cedar Hills</u>		<u>Philadelphia PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane - Church Hill Md</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 12 1959</u>		24b. REGISTRAR'S SIGNATURE <u>L. S. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

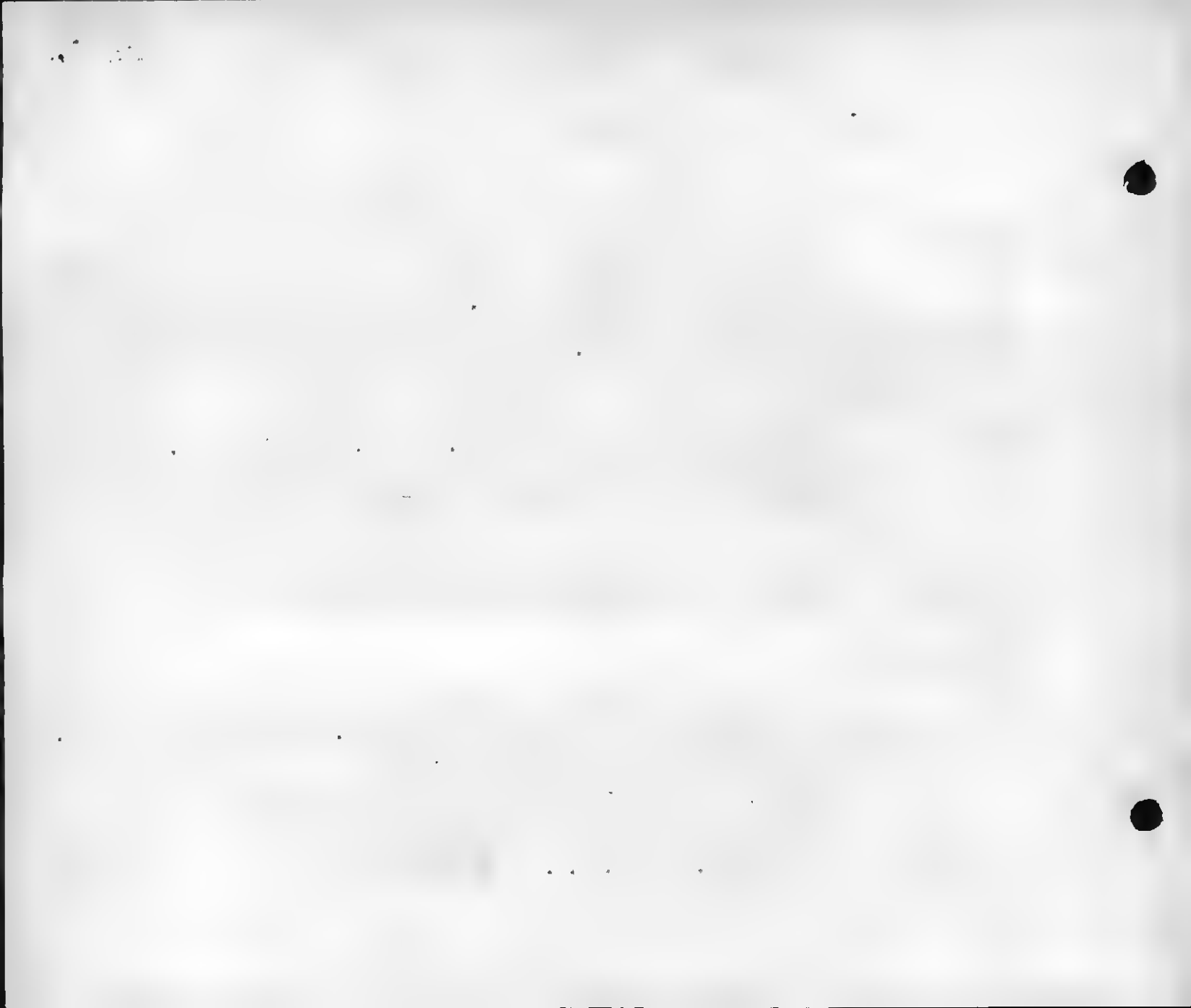
00741

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4 miles from Still Pond		d. STREET ADDRESS Black Rock Road	
3. NAME OF DECEASED (Type or print) RICHARD JAY NEWMAN		4. DATE OF DEATH Month January Day 14 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 24, 1926
9. AGE (In years last birthday) 32 yrs		10. IF UNDER 1 YEAR: Months 14 Days 19 Hours 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer copilot		10b. KIND OF BUSINESS OR INDUSTRY Aircraft Mfg.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Irving Newman		14. MOTHER'S MAIDEN NAME <i>Josephine Newman Stutz</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW2		16. SOCIAL SECURITY NO 216 22 8838	
17. INFORMANT Thomas A. Brandt, Kingsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple extreme injuries -- fragmentation of body 863 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Airplane crash	
20c. TIME OF INJURY Month, Day, Year 11:55 PM 1/14 19 59		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Nr. Still Pond Kent Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Russell S. Fisher</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 17/59	
22c. NAME OF CEMETERY OR CREMATORY Grace		22d. LOCATION (City, town, or county) (State) Barto Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw & Hipton</i>		24a. REC'D BY REGISTRAR DATE JAN 19 59	
ADDRESS Hampstead Md		24b. REGISTRAR'S SIGNATURE <i>Charles E. ...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

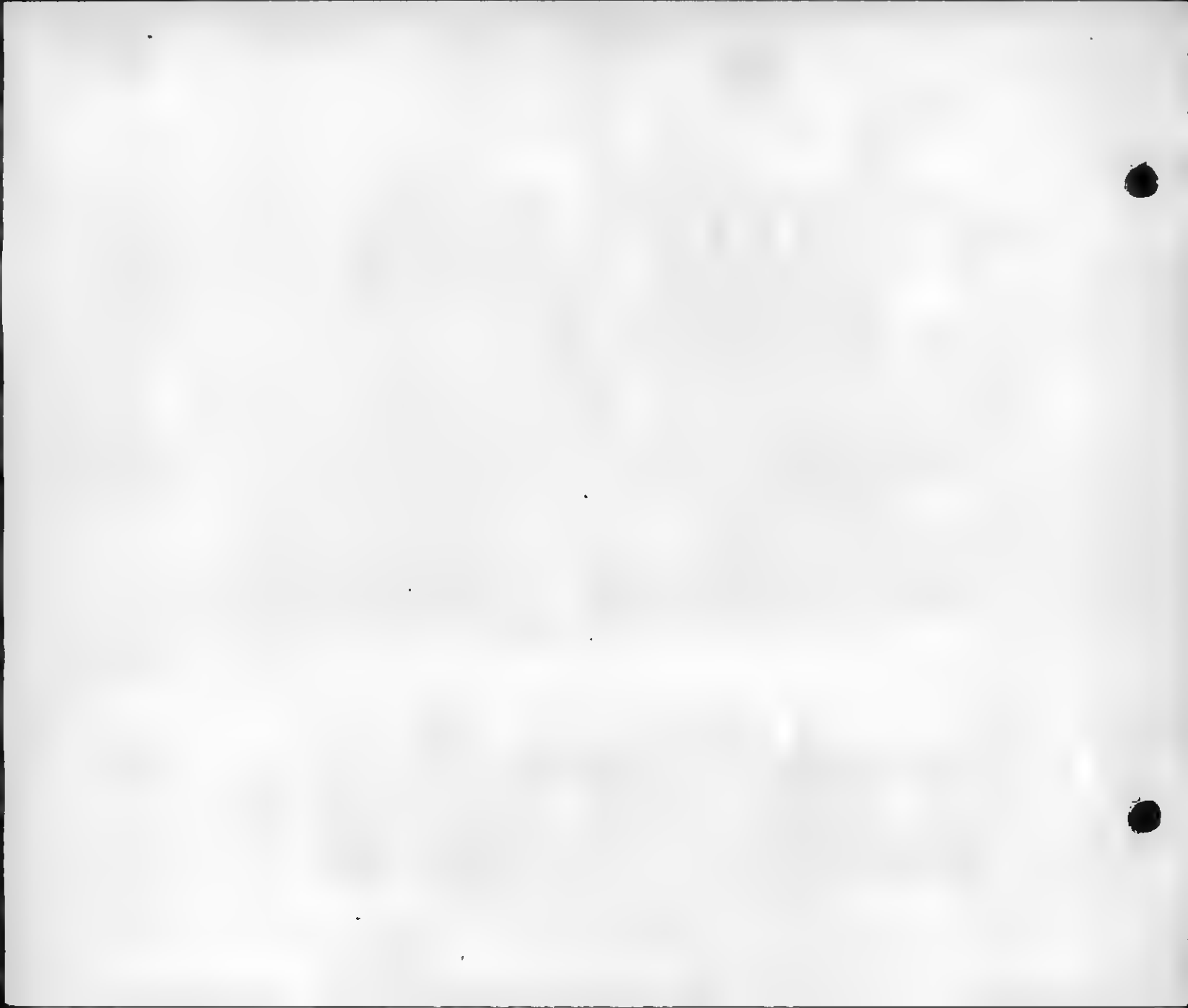
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Mont</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown FMD</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Elotita</u>		e. STREET ADDRESS <u>St. Elotita</u>	
3. NAME OF DECEASED (Type or print) <u>Tempie</u> First <u>Norris</u> Middle Last		4. DATE OF DEATH <u>Jan. 7, 1959</u> Month <u>7</u> Day <u>19</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/8/83</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Maria unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>don't know</u>	
17. INFORMANT <u>Mrs. Marcia Wilson</u> Address <u>Chestertown, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) <u>Unknown causes - probably natural</u> <u>7:15 p.m.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Famed dead about 6:30 p.m. - Had previously been in apparent good health - Had had</u> (c) <u>no medical attention</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no medical attention</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <u>Robert W. Fair</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/7/59</u>	
EXAMINER'S NAME (Type) <u>Robert W. Fair</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Elotita Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walley</u>		24a. REC'D BY REGISTRAR <u>Jan 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>C. L. S. Thomas</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home or, Page 4 to the funeral home. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



753 CERTIFICATE OF DEATH

00743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. COUNTY <u>Fairfield</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairfield</u>	
c. LENGTH OF STAY IN 1b <u>3 Days</u>		d. STREET ADDRESS <u>96 Rock Major Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Perry</u> Middle <u>B</u> Last <u>Patterson</u>		4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24 1908</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Manager</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Remington Arms</u>	
13. BIRTHPLACE (State or foreign country) <u>Alabama</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>W. S. Patterson</u>		16. MOTHER'S MAIDEN NAME <u>Rosa Stucky</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>578-07-8026</u>	
19. INFORMANT <u>Edwin H Pock</u>		Address <u>1419 27th St NW DC.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:30</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rock Hall</u> DATE SIGNED <u>1/6/59</u>			
ACTUAL SIGNATURE <u>William H. Gentry</u> M.D.			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>1-8-59</u>	<u>1-8-59</u>	<u>Oak Lawn</u>	<u>Fairfield</u> <u>Conn</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar R Lane</u>		24a. REC'D BY REGISTRAR <u>1/8/59</u>	
ADDRESS <u>Church Hill</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kears</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



743

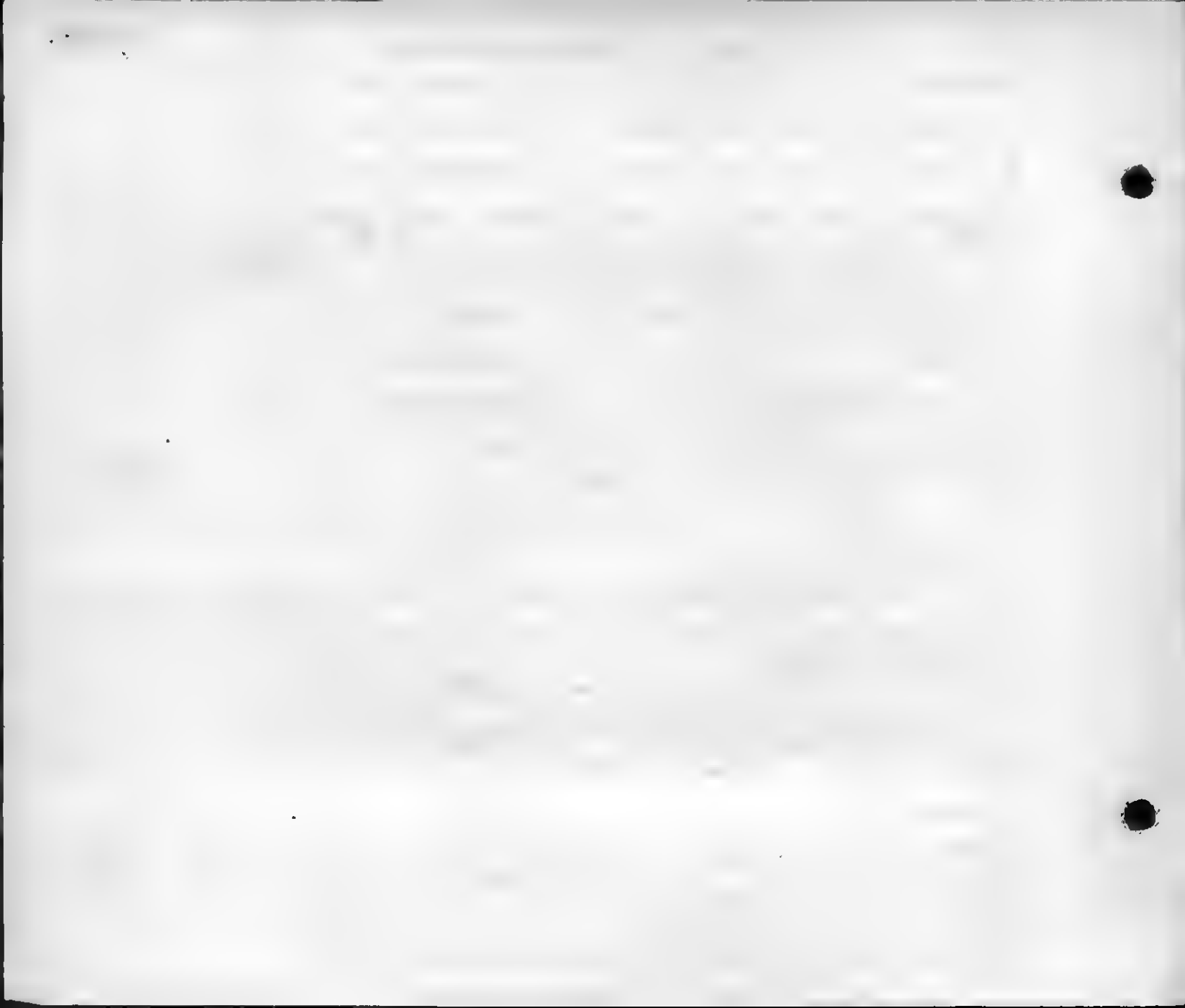
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fred Middle Merritt Last Seney				4. DATE OF DEATH Month January Day 13 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 15, 1874		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Salisbury Seney				14. MOTHER'S MAIDEN NAME Frances Cecil			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-34-9937		17. INFORMANT Hospital records, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene, right 4th toe, due to peripheral ischemia & arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH a few minutes Many years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/18/ 1958 , to 1/13/59 , 19 , that I last saw the deceased alive on 1/13/59 , 1959 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 1/13/59							
ACTUAL SIGNATURE Robert W. Farr M.D. Chestertown, Md.				DATE SIGNED 1/13/59			
PHYSICIAN'S NAME (Type) ROBERT W. FARR							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		JAN. 16		CHURCH HILL		CHURCH HILL MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Kane				ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR DATE JAN 1 1959	
						24b. REGISTRAR'S SIGNATURE Wm. S. Evans	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

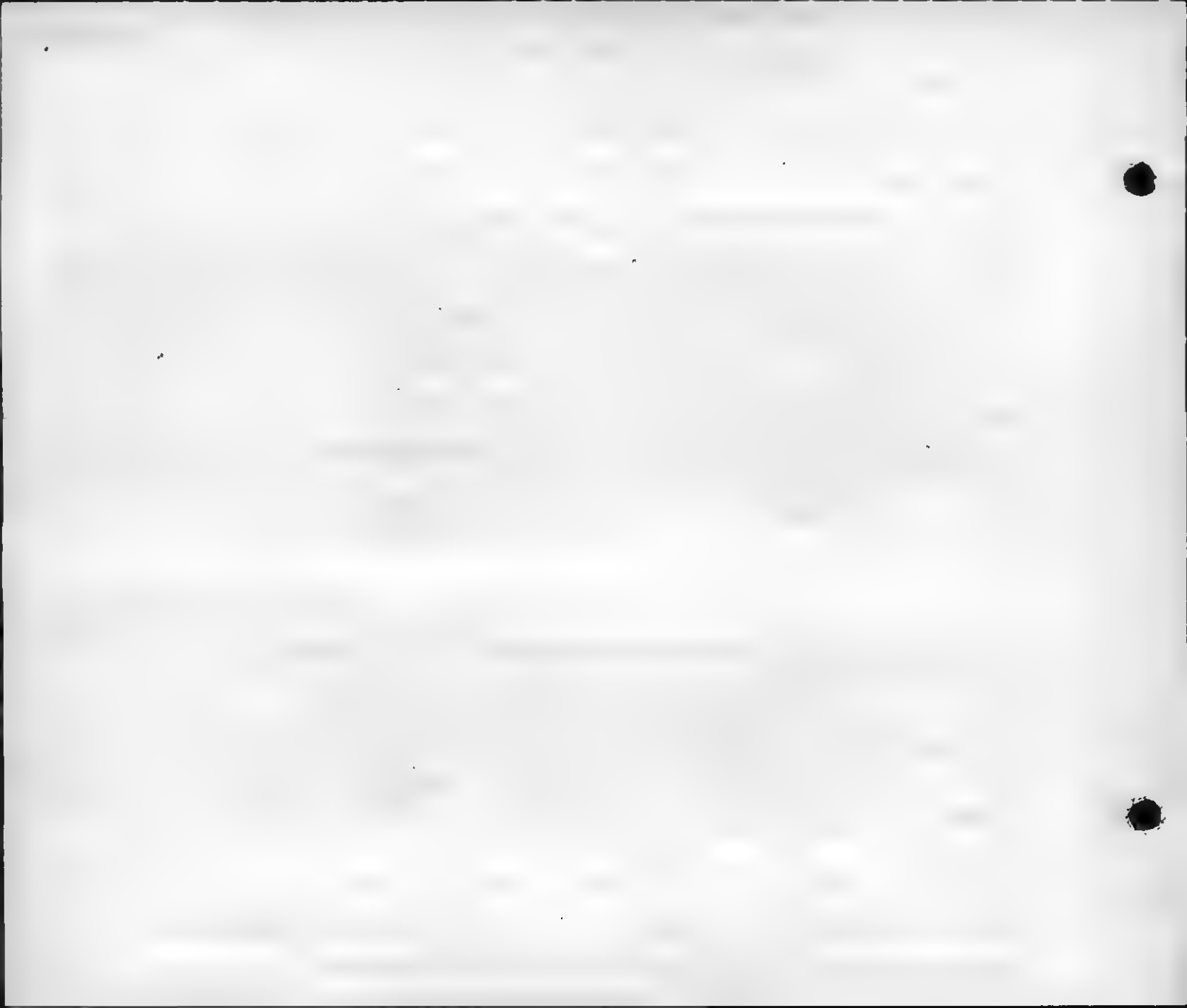
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CERTIFICATE OF DEATH

00745

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) Troves Nursing Home				d. STREET ADDRESS -----			
3. NAME OF DECEASED (Type or print) First James Middle D. Last 1959				4. DATE OF DEATH Month 1 Day 27 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1911	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 1 Days 15	IF UNDER 24 HRS Hours 1 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY Shoe Store		11. BIRTHPLACE (State or foreign country) Ill.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME James D. 1901			
14. MOTHER'S MAIDEN NAME James D. 1901				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --- (If yes, give war or dates of service) ---			
16. SOCIAL SECURITY NO. unknown				17. INFORMANT Troves Nursing Home Address Kennedysville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senile debility 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Degeneration of the heart muscle DUE TO (c) Pylonephritis							INTERVAL BETWEEN ONSET AND DEATH 4-5 years 4 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. Month 19 Day 19 Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Oct. 27, 1958 to Jan 8, 1959 , that I last saw the deceased alive on Jan 7, 1959 , and that death occurred at 8:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE GEZA KORALEWSKI				ADDRESS (Street, city or town, state) MILLINGTON, MD		DATE SIGNED 1-9-59	
PHYSICIAN'S NAME (Type) GEZA KORALEWSKI							
22a. BURIAL, CREMATION, REMOVAL (Specify) 1/12/59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy				ADDRESS		24a. REC'D BY REGISTRAR	
						24b. REGISTRAR'S SIGNATURE	
				DATE JAN 12 '59			



755

CERTIFICATE OF DEATH

00746

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Chestertown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Trew Farm Quaker Neck		e. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Lillie Middle May Last Trew		4. DATE OF DEATH Month Jan. Day 3 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1881
9. AGE (In years for birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wesley Hadaway		14. MOTHER'S MAIDEN NAME Margaret Copper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Wesley Trew		Address Chestertown R.D. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency DUE TO (c) Cardio Vascular Diseases			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 1, 1958 to Jan 3, 1959 , that I last saw the deceased alive on Jan 2, 1959 , and that death occurred at 6:14 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rock Hall DATE SIGNED ACTUAL SIGNATURE Norbet C. Nitsch M.D. Rock Hall, Md. PHYSICIAN'S NAME (Type) Norbet C. Nitsch			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/5/59	22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE JAN 6 '59
		24b. REGISTRAR'S SIGNATURE Arthur L. Thoms	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 215 Queen St (South)		e. STREET ADDRESS 1 215 S. Queen St	
3. NAME OF DECEASED (Type or print) Raymond First Middle Last Yorker		4. DATE OF DEATH Jan. 5, 1959 19	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1881
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY various	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Yorker		14. MOTHER'S MAIDEN NAME Ellen unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 12-14-4807	
17. INFORMANT Louise Yorker Address Chestertown, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic cardio vascular disease 422.1 DUE TO Generalized Arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) many years DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , to Jan. 5 , 19 59 , that I last saw the deceased alive on Jan. 5 , 19 59 , and that death occurred at 2:30 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr M.D.		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 1/6/59	
PHYSICIAN'S NAME (Type) Robert W. Farr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 8, 1959	22c. NAME OF CEMETERY OR CREMATORY Janes Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR JAN 7 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

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CERTIFICATE OF DEATH

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1941

Blank form with horizontal lines for text entry.

Handwritten text on a dark background, possibly a signature or date.